CENTRE-STAGING SAFETY OF DELIVERY

Moving beyond the Home vs. Institution Debate

Women's Voices Series - 3

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The Women's Voices Series

Rural Women's Social Education Centre (RUWSEC), a grassroots women's organization based in Chengalpattu, Tamil Nadu has been working for women's health through empowerment for close to three decades now. One of RUWSEC's priority areas of interest has been to conduct research from a women centred perspective.

From 2008 onwards, RUWSEC started conducting periodic meetings with grassroots women in order to understand their stands on various issues. The first of these meetings began when the organization had to take a position on the various contentious portions of the draft Assisted Reproductive Technology (Regulation) Bill, 2008. It was felt that it was important to learn from women themselves what they felt about the various issues being raised. The meeting itself was revealing in that some of the stands of the feminist movement did not seem consonant with what women themselves wanted. A need was therefore felt to take the process forward with other women's health issues too. And thus was born the Women's Voices series.

We hope this series will help people working on women's issues incorporate grassroots perspectives in their own struggles for rights and justice.

CENTRE-STAGING SAFETY OF DELIVERY

Moving beyond the Home vs. Institution Debate

Introduction

Safe motherhood and maternal mortality have been on the global health agenda for sometime. The fifth Millennium Development Goal is to reduce maternal mortality by three fourths between 1990 and 2015. Several recent policy initiatives in India have focused on maternal health. The National Rural Health Mission (NRHM) has provided funding at all levels of the health system with maternal health as one of its key areas of interest. The Indian Public Health Standards provide a comprehensive package of maternal health services to be available at various levels of facilities. However, the major policy initiative of the Government of India towards this has been to push for greater institutionalization of deliveries – this has been furthered by the Janani Suraksha Yojana (JSY) that provides cash incentives for institutional births.

Several of us working on maternal health issues have been concerned about this policy of an exclusive focus on institutional deliveries and a total lack of attention to social determinants of maternal health. Not even the many health systems-related barriers to better maternal health services like lack of Emergency Obstetric Care (EmOC) facilities and accountable referral systems are being addressed. This seems to be based on the presumption that mere institutionalization of deliveries would automatically make deliveries safe and lead to reductions in maternal mortality and morbidity. International evidence is to the contrary - a comparison of maternal mortality data of 21 countries shows that lower maternal mortality ratios have a higher correlation with met need for EmOC rather than rates of institutional delivery or deliveries

conducted by skilled birth attendants[1]. Several small studies from various parts of India have also shown the problems with this approach of exclusive focus on institutional deliveries. Evaluations of the JSY show that while institutional deliveries have increased after the introduction of the scheme in many states, the quality of care at these institutions continues to remain poor. An impact evaluation of the JSY published in the Lancet in 2010 uses data from two district level household surveys[2] - this shows that JSY had a significant effect on increasing antenatal care and in facility births and seemed to have a positive effect on reducing perinatal and neonatal deaths. It was too early to examine the impact on maternal mortality, but some issues such as discharge of women in less than 48 hours following delivery cause concerns about the implications for maternal morbidity.

Tamil Nadu has one of the lowest maternal mortality ratios among the various Indian states. Several factors have contributed to this - social reforms resulting in better gender equity and progressive health policies irrespective of party politics has been one of the main factors[3]. This has resulted in several health system initiatives to address maternal mortality. Maternal death audits help analyze the cause of maternal deaths and institute systemic changes. The Muthulakshmi Reddy scheme provides cash assistance of ₹ 6000/- to women delivering in institutions - this is meant to cover costs related to wage loss and to improve nutrition of the pregnant woman. Following implementation of National Rural Health Mission (NRHM), a recent focus has been to help Primary Health Centres (PHC) conduct deliveries - this has resulted in an increase in the proportion of deliveries in public sector facilities.

Thus, Tamil Nadu has instituted several interventions to help women access delivery services in the public sector closer to home. At the same time, it is important to ensure that any unforeseen negative

consequences are identified and actions for course correction taken so that gains could be consolidated. Reports from the field about women being persuaded to deliver only in PHCs and reports about neonatal morbidity and mortality reinforce concerns of health activists and public health professionals that institutional deliveries in themselves would not ensure safety of delivery.

In order to understand further issues concerning safety of institutional deliveries and to bring together the experiences of various people working on this issue in Tamil Nadu, a meeting was organized in Chennai on September 19, 2009 by Rural Women's Social Education Centre (RUWSEC), Coalition for Maternal and Neonatal Health and Safe Abortion (CommonHealth) and Makkal Nalavazhvu Iyakkam (Jan Swasthya Abhiyan, Tamil Nadu). The participants included doctors, researchers, academicians, staff of non governmental organizations, development professionals, representatives of Positive Women's Network, all of whom had worked extensively on Maternal and Reproductive Health issues. The list of participants is given in Annexure1.

The meeting began with an introduction to RUWSEC, Common Health and Makkal Nalavazhvu Iyakkam. Dr Subha Sri, of RUWSEC and CommonHealth, introduced "CommonHealth" as a coalition of people and organizations working on Maternal and Neonatal Health and Safe Abortion issues. The Coalition carries out advocacy through different constituencies. She also introduced Makkal Nalavazhvu Iyakkam who was a co organizer of the meeting. Makkal Nalavazhvu Iyakkam is the Tamil Nadu unit of the People's Health Movement and works on health right issues. It is also presently involved in community monitoring of the National Rural Health Mission in Tamil Nadu. The network also focuses on the issue of privatization of health care and its impact on marginalized people.

Following a round of self introductions by the participants, the objective of the meeting was presented. CommonHealth and Makkal Nalavazhvu Iyakkam were attempting to move the discourse regarding maternal health care from "institutional delivery" to "safe delivery" - that the focus of policy makers and programme implementers should be on whether deliveries are safe, irrespective of where they take place, rather than only on whether they were institutional. It was hoped that the present meeting would serve to initiate discussion on pregnancy, delivery and newborn health concerns in Tamil Nadu based on participants' field experiences. It was also hoped that participants would attempt to define "safe delivery" from the woman's and baby's perspective and develop criteria, both technical and non technical that would define a safe delivery. It was suggested to have an action plan emerging out of this consultation.

Research Presentations

Three initial presentations were made to orient the participants on the present context of Maternal Health in Tamil Nadu and to trigger further discussion on the issue. The presentations are attached as Annexures 2,3 and 4.

Dr Balasubramanian from RUWSEC presented a research study on Utilization of Delivery Care Services in Tamil Nadu which was conducted by RUWSEC. The study examined the implications of recent reforms in Tamil Nadu on access to maternal and reproductive health care by rural women. The study was done in five districts of Tamil Nadu. The total sample consisted of 494 women all of whom had delivered a child within six months before the study. This study found that 98% of all deliveries were in an institution, and 80% were in public sector institutions. A large majority of deliveries of landless women (81%) and women from

Scheduled Castes took place in a public facility. Costs of delivery in public sector institutions were significantly lower than in a private facility. Women were happy with the quality of services and the attitude of providers in Primary Health Centres. However, those delivering in government hospitals reported facing verbal abuse and having to make informal payments.

Following this, Dr Subha Sri made a presentation on "Translating medical evidence into practice – Health and Population Innovation Fellowship project learnings on the maternal health care situation in Tamil Nadu." The presentation focused on learnings from the field through a study to enable translation of evidence regarding Active Management of Third Stage of Labour (AMTSL) into practice. The presentation highlighted the fact that doctors had poor knowledge of AMTSL. Medical professionals rarely practised evidence-based medicine in delivery care, while practices with no evidence, such as giving antibiotics following delivery were routinely adopted. The study documented the corruption and informal payments that women had to make, and the verbal, emotional and physical abuse of delivering women by health care providers through various case studies.

The next presentation was by Dr Rakhal Gaitonde of Makkal Nalavazhvu Iyakkam, on quality of maternal and child health services in Tamil Nadu with indicators from the pilot phase of the Community Monitoring and Planning Programme. He pointed out that move towards institutionalization was happening not only with respect to deliveries. There was a systematic retreat from community-based services and a move towards facility-based services. He highlighted the following as important components of the context within which institutionalization was happening - the retreat of Health Inspectors, shift of the job role from Village Health Nurse to nurse, shift of immunization services from the village to PHCs, shift of Ante Natal Care from the village to the

institution and shift of delivery to the PHC and non functioning of sub centres. The Community Monitoring processes clearly showed that the dalit hamlets of villages lagged behind in accessing services from PHCs. He concluded by saying that it is essential to look into the capacity of PHCs and to initiate capacity building processes. He also stated the lack of accountability as an important issue to be looked into.

Issues and Concerns around Safe Delivery

The floor opened for discussions following the presentations. The session was chaired by Dr. Padmini Swaminathan of Madras Institute of Development Studies. All the participants shared their concerns around safe delivery. The consolidation of the sharing is given below.

- ✡ It was noted by one participant that institutional deliveries have been high in Tamil Nadu for several years now. The difference in the recent trend was the increase in deliveries in public sector facilities.

Concerns regarding maternal health

- ✡ While most participants welcomed the government's initiative to improve maternal health care and the trend of increasing number of deliveries in the pubic health system, several concerns were also expressed around this. The Muthulakshmi Reddy scheme that provided an incentive of ₹ 6000/- for each institutional delivery also raised some concerns.

    - It was felt that the woman should be allowed to exercise a choice regarding the place of her delivery. To use the ₹ 6000/- as a carrot for getting her into public facilities was considered inappropriate. Incentivization, it was felt,

was being used as a short cut for attracting people into the public sector facilities instead of regulating the quality of care and costs in the private sector. All these, it was felt, revealed that health is not perceived as a right by state officials.

✡ Several instances of poor quality of care in public institutions were shared.

- After the Muthulakshmy Reddy scheme was implemented, women were compelled to deliver in PHCs.
- Subcentres are not functional. Services at village and subcentre level have been withdrawn and all moved to PHC level. Participants felt grassroots services have to be strengthened by improving subcentres especially since transport facilities especially at night still pose a problem.
- Maternal anemia still continues to be a big problem.
- Though deliveries are conducted in PHCs, the actual conducting of deliveries in many cases was by the local dais who were engaged by the ANMs privately.
- Anecdotal instances of birth asphyxia and intrauterine sepsis due to poor management of labour and delivery were shared. These revealed that skills and knowledge regarding conducting a safe delivery were not adequate in health providers. Irrational practices like use of intramuscular oxytocin for augmentation of labour were also prevalent in public facilities.
- There were delays in referring complicated cases from the PHC to referral facilities. Emergency Obstetric Care (EmOC) facilities are still not available either at taluk or PHC level. Teaching hospitals were currently

seeing complications that they had rarely encountered previously. Several systemic roadblocks exist – admission to operation theatre time was for example 2 ½ hours in a medical college due to paucity of anaesthetists.

- Medicalization of pregnancy and birth was rampant.
- Irrational practices like unnecessary caesareans increase morbidity.
- Irrational use of intramuscular oxytocin for augmentation was also seen in government facilities – also an injection culture was prevalent leading to patient demand for the same – this results in birth asphyxia, uterine rupture and other complications.
- Complications were referred only to government hospitals far away even if a NGO hospital or private medical college with tertiary facilities existed close by, endangering the life of the woman.
- The following question was raised - Are we ensuring requisite training in knowledge and skills to make PHC deliveries "safe" deliveries? It was felt that technical facilities are invested in, but not essentials like blood storage or human resources.

✡ Recording of maternal mortality and morbidity was seen as being inadequate. Several instances of maternal mortality and morbidity that went unrecognized by the system were shared.

- One participant from a Non Governmental Organization (NGO) run hospital in a remote tribal area shared stories of three recent maternal deaths in a 7 village cluster. These were due to postpartum haemorrhage, eclampsia and sepsis. This area was treated as a no man's land as it

fell at the borders of 3 different districts and these deaths were not reported by any PHC. The participant sharing this episode wondered that if maternal deaths are not reported, what then of child mortality.

- A participant from Kaniyambadi block noted that they were seeing an increasing number of maternal deaths – 5 every year now compared to 1 or 2 per year earlier.
- Maternal mortality reviews bring out that even post facto modifications are made in patients' medical records in order to safeguard the interests of providers.

✡ It was felt by several participants that morbidity – maternal or child – is not being addressed.

Issues regarding neonatal health

✡ A paediatrician from a government medical college shared her concerns through a written communication, which was read in the meeting. Her major concern was that she was now seeing more instances of neonatal morbidity and mortality than in the past among cases referred from PHCs to her facility. The following concerns were raised.

- Inexperience of nurses in identifying high risk cases.
- Because of targets for deliveries allocated to each PHC, even high risk women were not being referred to higher centres even if the woman wanted to do so.
- No proper suction facility in PHCs resulting in neonatal deaths due to meconium aspiration.
- At taluk and district level, both human resources and equipment for neonatal care / transport were inadequate. They often did not have even oxygen. Equipments are of

low quality and break down in a few months of purchase. As a consequence, complications seen in PHCs had to be referred to teaching hospital often a large distance away.

- Lack of facilities/training for neonatal transport in the ambulances provided as part of the Emergency Management and Research Institute (EMRI or 108) services – no ambubag facility, no covering of babies adequately.
- 108 ambulance service refused to transport babies from one medical college to another for tertiary intensive care. Transport is allowed only from a PHC to a medical college.

✡ Other participants felt that no follow up child development services were available in the first year of life resulting in an increase in disability, learning disorders.

All of these revealed that an institutional delivery does not automatically translate into a safe delivery.

Suggestions for improvement

✡ Documentation of cases of neonatal morbidity/mortality like birth asphyxia.

✡ Confidential enquiry into gaps in system.

✡ Training in delivery and neonatal resuscitation for PHC staff.

✡ Joint audit of preventable morbidity/mortality at primary, secondary and tertiary levels from a problem solving paradigm with stakeholders from peripheral level.

✡ Policy change initiatives at key stakeholder level.

✡ Training and equipment investment in Neonatal resuscitation.

✡ Equipments to be bought by each unit according to their own needs/choice.

- ✡ Database of all babies born and followed up for one year to identify disability.

Other related issues

- ✡ Several instances of corruption in Muthulakshmy Reddy and JSY schemes were shared.
    - Very often, the mothers did not receive the full ₹ 6000/- they were eligible for due to informal payments to staff of the health care system.
    - There were also several delays in receiving the money and very often it was not given in the antenatal period as originally envisaged, thereby defeating its purpose of supporting the antenatal care and nutritional requirements of the mother.
    - Though not specified as such in the Government Order, the benefits were only given to women delivering in government facilities and not in private/NGO run facilities. Anecdotes of immunization services not being provided to babies delivering in NGO hospitals were shared.
- ✡ Women from Positive Women's Network (PWN+) spoke about the discrimination HIV +ve women face in public hospitals.
    - They are abused verbally, especially by the lower level staff. Also very often, confidentiality regarding their +ve status is broken.
    - There was a suggestion that abuse within health facilities be brought under the purview of the Women's Commission.

- Refusing to treat a patient for reasons like their +ve status was termed both unethical and unlawful.

- Special needs of special groups need to be addressed – there was a need for institutions for provision of Prevention of Parent to Child Transmission (PPTCT) services.

- District hospitals in specific districts refer all +ve patients to higher centres – women deliver on the way, this causes problems in getting benefit from the Muthulaksmy Reddy scheme.

- No counselling on breastfeeding is given to +ve women.

- Very often they are referred to the doctors' private facilities.

- Staff conducting delivery don't even wipe babies properly – this defeats the whole purpose of giving nevirapine.

- Family Planning surgeries are not done – this causes problems to the woman due to repeated pregnancies. Doctors also refuse to do abortion.

- Systems have been established to sort these out at care centres – but they don't work.

- One participant shared experiences from Manipur - +ve women don't have access to safe abortion services in PHC/CHC – there is a lot of stigma and discrimination.

- Participants felt that problems and needs of +ve women need to be mainstreamed in all issues.

✡ One participant said that Sample Registration System data shows overall reduction in neonatal morbidity and mortality,

also in Maternal Mortality Ratios (MMR) – more cases may be coming to light because of shift of deliveries to PHCs, and it may be too early to say rates are going up.

- ✡ One of the participants who was a senior official in the health department shared historical evidence regarding trained midwives reducing MMR in Sweden. He felt the present system of 1 1/2 years training of Auxiliary Nurse Midwives (ANM or Village Health Nurse - VHN - in Tamil Nadu) was totally inadequate. Training modality at present is that trainees work in shifts – there is no accountability to the woman. A nurse has to follow several women from admission to delivery to postnatal ward in order to learn the requisite skills. 15 day training given now to nurses is inadequate – at least 6 months each in obstetrics and gynaecology and pediatrics departments is necessary. VHNs and dais are more amenable to training and change in practice, he felt, compared to doctors and nurses.

- ✡ He also shared experience of the "Incident prevention approach" implemented in one district - a network of people including pregnant women, ANM and Joint Director were given the Deputy Director of Health Service's (DD) "magic telephone no." - the DD was then called for any problems in maternal health care for eg. if birth companion not allowed, if undue delay. This brought down maternal mortality – from absolute numbers of 45 to 6. Based on this experience, 108, a centralized call service for emergencies, was formed. Now the demand is to have an exclusive line for Maternal Child Health (MCH) care. He felt that analysis of an event post facto may not be as useful as "incident prevention". While this may be an individual's initiative – an emergency MCH helpline may be a sustainable way to upgrade this.

- Another participant responded to this by saying that systemic apathy at all levels was apparent and this was also associated with corruption. While women with extra risk like heart disease, HIV +ve women need to be identified, a universal approach of providing services for all is required. Therefore, an incident prevention approach has its limitations. Focus on emergency referral, while important, again is not enough.

- Some participants felt that a universal approach was necessary – incident prevention focuses only on mortality, not on morbidity. Especially in a situation where in Tamil Nadu, mortality is going down, more attention needs to be paid to prevention of morbidity. Neonatal morbidity is especially important especially in a situation when number of children born per couple is limited due to small family sizes.

- Road transport needs to be improved.

- Health education and communication is a basic preventive step and also a right – these services are inadequate.

- Networking has to happen between various government departments like Integrated Child Development Scheme (ICDS), health education and at various levels within health sector – primary, secondary and tertiary.

- Adolescent care and nutrition needs to be emphasized. Adolescent sexual health modules need to include life skills, gender, nutrition etc. - health education has to be given at the right age.

- One of the participants felt that a public private mix like the Chiranjeevi Yojana of Gujarat had to be explored – there was some difference of opinion on this.

At the end of the discussion, Dr.Padmini thanked the forum for the rich information and shared that a Memorandum of Understanding has been signed between Tata Institute of Social Sciences and Ministry of Labour to study the maternity benefits at field level which could result in broadening the definition of safe pregnancy. She also added that it is evident from the discussion that institutional delivery is not equal to safe delivery. To change the situation we need to have a body of knowledge to understand the processes, procedures, skills and infrastructure that would lead to safe pregnancy and delivery. It is very essential to have a systemic approach to deliver efficient services. We also have to change indicators of development – from "institutional delivery" to "safe delivery".

To consolidate the discussions the participants were asked to write down the top three concerns emanating from the discussion about safe pregnancy and delivery on slips of paper. These were then thematically classified and put up on the board. The broad thematic areas are given below.

Health system: Access to health care, transport, referral services, equipments, medicine, hygienic sanitation facilities, maternal and neonatal morbidity, neonatal mortality.

Networking: Public private partnership, networking among Government departments and Non Governmental Organisations

Monitoring: Mechanism for monitoring, stopping all forms of abuse and corruption, stopping incentivisation, making the sub centre functional

Capacity Building: Training on skills and attitude. The required standard of training should be defined.

Research: Defining safe delivery, systematic documentation of processes and systems, research on gaps in service provision.

Women with HIV/AIDS: service provision according to guidelines without stigma and discrimination, capacity building on these issues, adequate training on PPTCT, counselling on breast feeding to +ve mothers.

Community: Training for Traditional Birth Attendants, health education communication on preventive and promotive health for adolescent and adult groups.

Defining Safe Pregnancy:

The post lunch session concentrated on defining safe delivery. Dr Sundari Ravindran chaired the session. It was suggested that the forum could either come up with a fresh definition or they could work on the definition drafted by members of CommonHealth earlier at a meeting at Mumbai. The forum opted to work on the existing definition and modify it based on the morning discussion.

The definition suggested by CommonHealth is given below.

Definition of safe delivery - draft

Delivery whether at home or in an institution is "safe" when

- ✡ Both the mother and the newborn survive.
- ✡ There is no maternal or neonatal morbidity, both short-term and long term.
- ✡ The woman and the newborn do not receive unnecessary/ irrational procedures or drugs, and receive the essential/ appropriate care (both complicated and uncomplicated).

- ✡ Those with complication receive emergency care and referral and transport.
- ✡ Those with complication receive the appropriate technical standard of care.
- ✡ The woman receives all the relevant information and is consulted in care give to her.
- ✡ The woman and the newborn are treated with dignity.
- ✡ The woman and the newborn are not discriminated in any way.
- ✡ The woman and the newborn are not abused in any way.

The participants took this as a base document and suggested modifications. The main suggestions are given below.

- ✡ The issue of corruption should be mentioned.
- ✡ Both public and private sector should be included in the definition.
- ✡ It is better to define safe pregnancy rather than safe delivery so that the definition would be broader including antenatal, neonatal care and social issues around pregnancy. It would also then include issues of safe abortion.
- ✡ Interest of special groups like HIV positive women, single women, migrants, women with mental health issues, dalit women and tribal women should be included.
- ✡ The woman in labour should be given space for decision making.
- ✡ The definition should include antenatal, neonatal, postnatal and infant care .

- Long term well being and development of the child should find place in the definition.
- Right to have safe abortion should be mentioned.
- Accountability - right to ask questions, duty to answer, be answerable - should be added. Monitoring system independent of government control and pressure should be mentioned.
- Incentivization should be stopped.
- Service provision should be responsive to the needs of the community.
- Standardization of procedures and systems functioning need to be stated.
- Education on preventive health components for adults and adolescents should be added.
- No discrimination for higher order births.
- Safety at work places, maternity benefits and welfare schemes like crèches, child care facilities should be mentioned.
- Services should be available at a cost affordable to the community.

Action Plan:

The participants then moved to forming an action plan. The following actions were agreed on with groups of participants taking responsibility for each.

- A Statement of concern will emerge out of the report. Attached as Annexure 5.
- A review paper will be brought out with information and data available till now and the next steps in planning processes.

- An instrument for measuring safe pregnancy and delivery will be evolved with indicators on what should be there and what should not be there.
- Finalization of working definition on "safe delivery" with women's perspective would be brought out.

CENTRE-STAGING SAFETY OF DELIVERY

Moving beyond the Home vs. Institution Debate

Following the meeting in Chennai with academicians and activists to understand issues concerning safety of institutional deliveries, a subsequent meeting was held with grassroots women leaders to understand their perspectives on the issue. This meeting was organized by RUWSEC in Chengalpattu on 17/12/09. The meeting was attended by grassroots women leaders from RUWSEC's federation and also from other organizations. Efforts had been made to invite a few traditional birth attendants and a few women who had recently delivered to understand their experiences but most of them could not attend the meeting due to various reasons. Separate interactions are planned with them to understand their views on the issue. A list of the participants is provided in Annexure 6. The meeting was facilitated by Dr Subha Sri of RUWSEC.

The meeting began with self introductions by all the participants. Following this, the facilitator introduced the objective of the day's meeting as to share women's experiences around pregnancy and childbirth and to use these to understand their perspectives on what actually constitutes a "safe delivery".

Gaps in maternal health care services

As a first step, participants were asked to list out what they thought were gaps in maternal health care services in Tamil Nadu today. The following points were listed in the open group and are classified here thematically.

✡ Factors related to home and family.

- Ignorance of patients and their relatives resulting in delay in seeking care.

- Pregnant women not giving adequate care to their own health.
- Lack of awareness of danger signs.
- Socio cultural factors - an incident of a woman having premature rupture of membranes but refusing to seek care because her husband was away was narrated - in this particular case, the baby had died.
- Domestic violence against the pregnant woman - details of a study in Maharashtra showing violence as the second most common cause of maternal death after post partum hemorrhage was shared at this point by the facilitator.
- Increased work load during pregnancy.
- In some instances the husband going abroad and staying away leaves the woman with no support during pregnancy.
- Repeated births of girl children.
- Economic difficulties in the family.

✡ Factors related to access to health care.

- Poor transport facilities.
- Lack of health care facilities close to where they live.
- Careless attitude of village health nurses

✡ Factors related to health care facilities.

- Poor quality of care by providers.
- Absence of doctors in the hospital.
- Delay in accessing higher level facilities as Village Health Nurses instruct the woman and family to deliver in the PHC to avail the benefit of Muthulakshmi Reddy scheme.

Requirements for safe delivery

Following this, the participants were divided into three groups and each group was asked to discuss what they thought would be the best case scenario if they themselves had to give birth and wanted a safe delivery - where would they want to give birth, what facilities would they like, what circumstances, who should conduct the birth. Following this, a summary of each group's discussion was shared in the larger group. The main requirements for a safe delivery that came up were as follows and are classified thematically below:

✡ Factors related to woman and family

- The woman should have the right to choose place of delivery.
- There must be good relations within the family.
- Intake of nutritious food for the woman.
- Awareness of important issues related to pregnancy and delivery for both the woman and her spouse.
- The woman should have knowledge regarding her personal hygiene.
- Knowledge of contraception and contraceptive methods.
- Knowledge regarding postpartum care.
- No dietary restrictions after delivery.
- Should have contact with the Village Health Nurse.
- The first delivery should be in an institution.

✡ Factors related to health care facility

- The place must have available sterile instruments / equipment for delivery and the woman must be able to trust that these are indeed sterile.

- Birth companions who can help and support the woman during labour and delivery must be present.
- Unnecessary drugs / injections eg. oxytocin augmentation should not be used during delivery.
- Basic facilities should be available. These were listed as follows:
    - Blood bank
    - Ambulance
    - Generator back up
    - Gynaecologist
    - Paramedical staff to help with complications.
- Unnecessary procedures like caesareans should not be done for commercial interests.
- Immunization, antenatal care should be available including lab tests like hemoglobin levels.
- The first delivery should be in an institution.
- There should be no violence or abuse of women by medical workers.
- Health providers should not discriminate between women in quality of care/nature of treatment based on ability to pay.
- Counselling for the woman by medical staff should be an integral part of delivery care.
- The facility should have adequate privacy, toilet and water facilities.

Following this, the factors were further classified by the larger group as follows. These were seen as constituents of a safe delivery.

- ✡ Support from family - This included nutritious food, adequate importance given to medical care and promotion of physical and emotional health.

- ✡ Basic medical facilities - These included sterile instruments, access to a health care facility close by, and presence of a gynaecologist and ambulance services.

- ✡ Other factors like presence of counselling services, absence of physical / emotional violence on the woman, absence of corruption, and presence of birth companion.

The facilitator initiated a discussion here as to whether deliveries could be conducted safely at home. A majority of the participants felt that this was not advisable. When asked about conducting deliveries in PHCs, many felt that this was okay if a gynaecologist was present. When challenged by the facilitator as to what the role of the gynaecologist was, the discussion concluded that since it would be practically impossible to have gynaecologists in every PHC, nurses and doctors present there must be trained in diagnosis and initial management of obstetric complications.

Following this, the facilitator asked the participants to list things that had changed over the past few years related to maternal health care in the state and also to classify them as things that have improved, have not changed or changed for the worse. The following table was generated out of this discussion.

Improved	Not changed	Worsened
✡ Basic medical facilities ✡ Transport facilities ✡ Increase in institutional deliveries ✡ Ambulance facilities ✡ Financial support by government ✡ 24 hour services ✡ Registration of pregnancies		✡ Village Health Nurse does not visit the villages frequently. ✡ Lack of awareness regarding maternal health care among villagers. ✡ Lack of right to choose place of delivery. ✡ Coercion regarding place of delivery. ✡ Absence of immunization at village level. ✡ Decline in quality of care in private facilities ✡ Increase in unnecessary caesareans. ✡ Treatment based on ability to pay in private facilities

There was some discussion within the group as to whether the factors listed above were uniform all over the state, especially with regards to some backward districts and tribal areas. It was felt that this was not so and these had to be contextualized according to various areas. Following this, the session broke for lunch.

"But why?"

In the post lunch session, the story of Sudha was presented. This was a case study of a woman facing a maternal complication and needing emergency obstetric care. This was followed by a "but why" exercise - the facilitator asked the question "why was Sudha pushed to such a situation" and for every response the question "but why" was asked again. This exercise produced a wide range of interlinked factors responsible for Sudha's situation. The pictorial representation of this exercise is attached as Annexure 7.

Sudha's story

Sudha is a poor woman living in a remote village. She has two girl children. She approaches a government primary health centre with labour pains for delivery. The doctor examines her and tells her she is severely anemic. Within two hours of admission in the PHC, she delivers a healthy girl baby.

Sudha starts having heavy bleeding after delivery. The 108 ambulance service is called and she is referred to the government district hospital. It takes 2 hours to reach this hospital that is 30 kms away. Her condition becomes critical by the time she reaches there. With critical care in that hospital, her condition improves and Sudha survives after great difficulty.

Why was Sudha pushed to this difficult situation?

Following this, the facilitator highlighted the two main policy interventions in the state today as regards maternal health care - institutionalization of deliveries and financial assistance to pregnant women (Muthulakshmy Reddy scheme). The participants were then asked to identify factors from the web drawn that would be

mitigated by either of these two policy intervention and rub them off the blackboard where they were written. To everyone's surprise, the participants found that none of the factors could be erased. This brought out the fact that very broad based interventions were necessary to improve maternal health.

Interventions to improve maternal health

In the final session, the participants were divided into three groups. Each group represented one level of administrative decision making - one was the village Panchayat, one the block level administration and one the district level administration. Each group was then asked to plan interventions at their level to improve maternal health in their area. Their discussions were then reported back to the larger group. These were as follows:

Panchayat level

- To provide basic facilities at the local subcentre (SC) and primary health centre.
- To provide clean drinking water at the health facilities.
- To ensure financial assistance for emergency transport.
- To provide toilet facilities.
- To eradicate mosquitoes.
- To provide for nutritious food for pregnant women.
- To ensure all support for safe delivery.
- To ensure training for counsellor, nurses and dais.

- To buy necessary instruments and equipment for safe delivery.
- To ensure 24 hour services in the subcentre.
- To ensure good road facilities.
- To buy essential medicines for the subcentre/PHC when in short supply.
- Develop a blood donors' list to help women who need emergency blood transfusion.
- Renovate the buildings of subentre / PHC by contacting the BDO.
- To provide telephone facility at SC/PHC.
- To provide generator/refrigerator facility at PHC.
- To ensure training of health workers in biomedical wastage disposal.
- To form a monitoring group at panchayat level and get feedback from clients regarding services.

Feedback from the larger group

- To arrange working of VHSC and Patient Welfare Society

Block level

- Map all government institutions and structures at Panchayat level with the help of Panchayat staff in order to involve all of them in activities to promote safe pregnancy and delivery.
- To understand how Panchayat funds are spent through meetings with Panchayat leaders and through studies.
- To federate Panchayat leaders at the block level.
- To arrange for building/renovating subcentres.

- To monitor working of Village Health and Sanitation Committees (VHSC) and ensure their functioning.
- To participate in planning of utilization of Patient Welfare Society funds for improvement of health care facilities.
- To work with NGOs for increasing awareness for improving women's health.
- Work with honest contractors to improve road facilities.
- Improve transport facilities.
- To ensure electricity for subcentres/PHCs.
- Train Anganwadi Workers regarding women's health issues.
- To utilize Panchayat untied funds for health to provide nutritious food for pregnant women.
- To provide loans for self help groups to grow vegetables and sell them at affordable prices.
- To conduct anemia camps and ensure follow up through VHNs.
- To arrange for grievance redressal through a dedicated grievance redressal day.
- To provide funds for construction of toilets in every village.
- To improve women's health through conducting mobile health camps in villages without access to health facilities.
- To provide basic facilities for health care workers to stay in villages.

Feedback from larger group

- To ensure various facilities like scan, caesarean facilities, tubectomy, blood bank, pediatrician, various service guarantees under NRHM are implemented.

District level group

- ✡ To ensure road facilities - To connect village roads, panchayat roads, and state and national highways.
- ✡ Women can choose to deliver at a facility close to them and of their choice - welfare schemes will provide financial assistance for this.
- ✡ To ensure cash assistance within 5 days of submitting request.
- ✡ To ensure provision of high quality nutri mix powder for pregnant women through ICDS.
- ✡ To provide immunization facilities at village level through mobile camps.
- ✡ To provide for blood and urine testing facilities at village level through mobile labs.
- ✡ To arrange for 24 hour presence of doctors and nurses at PHC on a shift basis.
- ✡ To arrange for continuing training of doctors, nurses and dais.
- ✡ To form monitoring groups.
- ✡ To arrange for safe referral of women who develop complications while delivering at PHCs.
- ✡ To arrange for submission of data at district level of women who have been referred due to complications.
- ✡ To monitor private health facilities and regulate charges there.
- ✡ To form monitoring groups to prevent unnecessary surgeries.
- ✡ If corruption is proved, to arrange for punitive action as per Indian Penal Code.
- ✡ To form an anti corruption force.

- To provide for stringent action against violence on women in labour.

Following this, there was some discussion in the larger group on the following issues:

- Can safe deliveries not take place in private institutions? Why then is the government insisting that women go only to public facilities?
- Can Panchayats not take any action against quacks?
- Are maternal deaths audited? Details of maternal death audit system in Tamil Nadu were shared by the facilitator in response to this.

Following this, the facilitator concluded the session by highlighting the attempt to move policy discourse from "institutional delivery" to "safe delivery". The views and perspectives emerging from this meeting would be incorporated into an evolving definition of "safe delivery" which could then be used to monitor whether births taking place are really safe.

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3. World Health Organization, Regional Office for South-East Asia. Safer pregnancy in Tamil Nadu: from vision to reality. WHO, 2009.

ANNEXURE I

List of Participants in consultation meeting 19/9/09:

Sl no.	Name of Participant	Affiliation
01	Ameer Khan	Community Health Cell (CHC)
02.	P. Balasubramanian	RUWSEC
03.	D.Selvi	RUWSEC
04.	S. Arul	Jeeva Jyothi
05.	Kuryan George	CMC, Dept of Community Health
06.	G.Shanthi	SRED
07.	Geetha .N	Consultant
08.	Asha Oumachigui	Puducherry
09.	T.K.Sundari Ravindran	RUWSEC
10.	K. Kulandaiswami	MAE Scholar, National Institute of Epidemiology
11.	D.Suresh	Tamil Nadu Science Forum
12.	P.Chandra	DAS-CBR
13.	Lalitha Regi	Tribal Hospital, Dharmapuri
14.	Ganthimathi Jayaramani	Red Cross and Red Crescent
15.	M.Grace	TNWF
16.	K.Bhavani	RUWSEC – Fed SWEET
17.	R.Sukanya	CHC, Bangalore
18.	Tanuja Charmi	CHC, Bangalore
19.	K. Thaiyalnayahi	PWN+
20.	Padmavathy	TPWN+
21	Padmini Swaminathan	MIDS, Chennai
22.	Bhavya	CHC, Bangalore
23.	Rakhal Gaitonde	CHC, Chennai
24.	Subha Sri	RUWSEC

ANNEXURE 2

Utilization of Delivery Care Services in Tamil Nadu

DIFFERENTIALS IN ACCESS TO AND UTILISATION OF DELIVERY CARE SERVICES IN TN:
FINDINGS FROM A RECENT STUDY

P. Balasubramanian
T.K. Sundari Ravindran

Rural Women's Social Education Centre (RUWSEC), Chengalpattu

OBJECTIVES

1. **An overview of levels and trends in utilisation of public and private sectors for delivery care in TN.**
2. **Inequities in access to and utilisation of delivery care services by caste and economic status.**
3. **Differentials in delivery care expenses by caste, economic status and source of care.**
4. **Women's perceived quality of care in the public and private sectors and the underlying factors.**

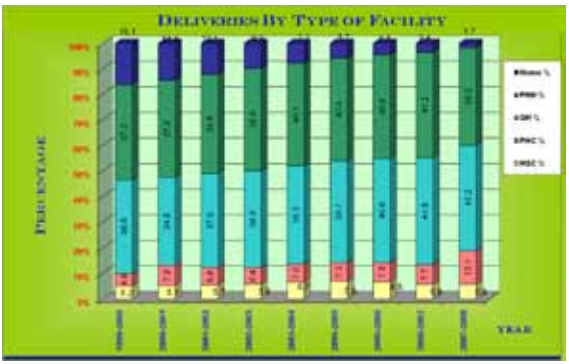
DATA AND PRESENTATION STRUCTURE

- RUWSEC - TN and ARROW - Malaysia

  Case study report on "Privatization and its consequences on Sexual and reproductive health care services in rural India - Case study in Tamil Nadu".

- Secondary data and field data - 5 Districts TN

SECONDARY DATA REVIEW



Increase in PHC deliveries has contributed to declining home and Pvt. Sector deliveries

THE STUDY PARTICIPANTS

- Covered 20 villages in 10 PHC area in 5 districts of Tamil Nadu
- Women who delivered a birth during the reference period of one year preceding the date of survey.
- Total sample was 494 women; 38% belonged to SC/ST groups; 85% women were not working outside the home; 86% landless, 85% aged 20-29 years.

DELIVERY CARE

Field Study

- Almost all were institutional (98%)
- 80 % of institutional deliveries were in a public health facility.

Reasons for selecting a particular source

- Public sector : 58 % selected the source for good services and availability of modern facilities, Free treatment and close proximity as the reason mentioned by 38 %.
- Of private providers, 68 percent mentioned good treatment and humane and caring behaviour of providers, followed 20 percent close proximity.

DIFFERENTIALS IN SOURCE OF INSTITUTIONAL DELIVERY

Caste, land owning status and age of the women showed some significant association with source of delivery care.

- As compared to SC/ST's, the deliveries of MBC and 'other' caste women were 6.3 and 17.4 times more likely to be in private hospitals.
- A large majority of the deliveries (81 percent) of landless women were in government facilities. But, women belonged to land owing households, nearly one third used private hospitals
- Women aged over 25 years were 2.4 times greater chances of having private institutions. It needs further exploration.

GREATER PROBABILITY OF C-SECTIONS IN THE PRIVATE SECTOR

The nature of delivery differs significantly by the source. The probability of c-section was several times higher in the private hospitals (4.2) than in government hospitals.

Field Study

COST OF DELIVERY CARE

- The cost of delivery here includes expenditure on doctor fees, Medicines, food and accommodation, travel, tips and expenditure on accompanying /bystander. For home deliveries, expenditure on person assisted the delivery and medicines and materials used were also taken into account.
- The median cost per institutional delivery was Rs 1250 which was about 4.5 times high as compared with a home delivery Rs 275.

Field Study

DIFFERENTIALS IN EXPENDITURE FOR INSTITUTIONAL DELIVERY

- The median cost per delivery in the private sector (Rs. 9950) was about 10 times high as compared with a public health facility (Rs.1000).
- Travel and food expenses were the largest component in public sector delivery costs, which accounted for half of the total delivery cost. Informal charges came next in terms of share of total expenditure.
- Among private hospital users, doctor's fees alone accounted for one third of the delivery cost. Drugs, bed charges, food and transportation costs were the other major costs involved.

Field Study

DIFFERENTIALS IN EXPENDITURE FOR DELIVERY

- Caesarean section costs almost three times more for a normal delivery.
- The median cost of a c-section in a private facility was Rs.15,000- It is about 7.5 times as high as compared with a public sector cost (Rs. 2000/-)

Field Study

WOMEN'S EXPERIENCE ON USING PUBLIC , PRIVATE FACILITIES

- Women in the study frequently mentioned that they were treated badly by health service providers in public sector facilities, especially hospitals. Another big issue was informal charges collected by various staff members. For example, Rs. 300 /- to show the baby, Rs. 100 /- for dais and other etc.
- At the same time, women who delivered in PHCs welcomed the government's move to provide 24x7 delivery care services in the PHCs. They felt that the quality of care in PHCs were relatively better than that in taluk or district t hospitals.
- Women spent a huge amount of money for delivering a baby in the private sector but at the same time they felt the quality of care is good in the private sector.

CASE STUDY

23 year old poor women of Kanyakumari district narrating her personal experiences in using PHC and District hospital

- *The services in medical college hospital are very bad. When I went there for my first delivery they asked money for this and that. They got Rs.300 to show the baby, Rs.200 to clean my inskirts and we should pay Rs.10, Rs.20 for the person who carries us in the wheel table. This is better but the words of the nurse and 'ayahas' are horrible. They talk very bad, they even beat. In that hospital they provided delivery care in an 'open space' for me. The women who accompanied me for delivery were also present. I felt very bad.*

CASE STUDY

Contd..

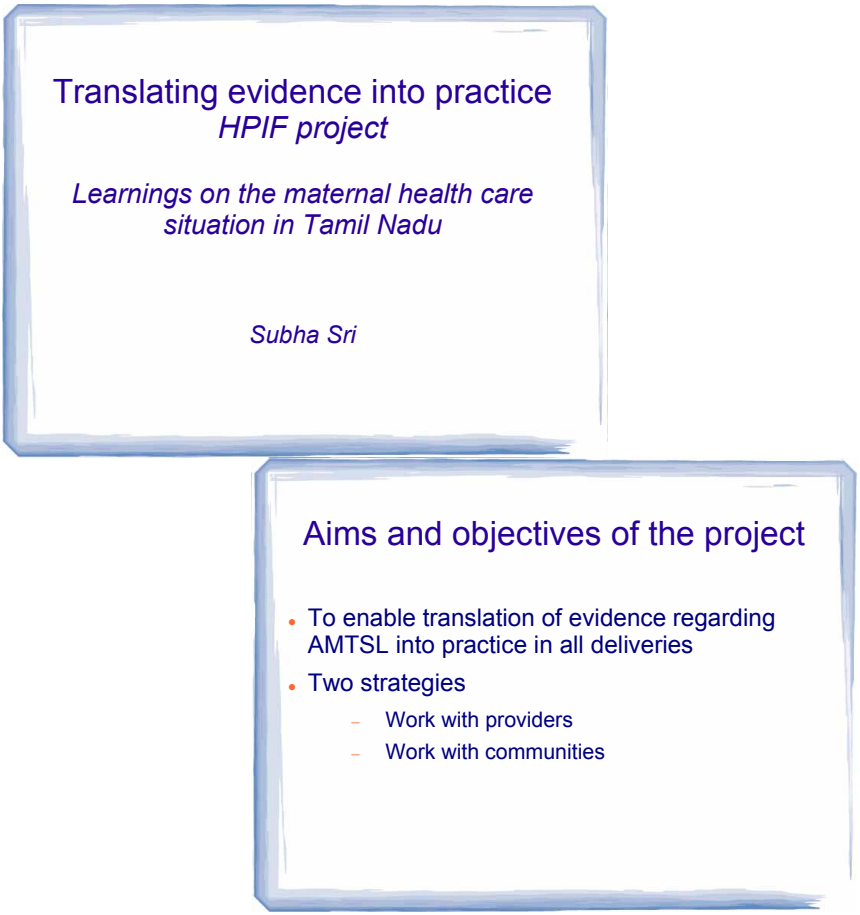
- *In the second delivery I got my labour pain around 12 o' clock mid night. They took me to the VelliSanthai PHC in a rented car. On the way we saw our area nurse and we asked her to accompany to the hospital. We spent Rs.100 on car hire charges. I had a normal delivery by 5 AM in the morning. They provided good care during delivery and they gave Rs.30 for food per day. We did not spend any money. On the 3rd day after delivery they arranged an ambulance and took me to Kolaichal government hospital for family planning operation. Even there we did not spend any money. They too provided good care over there.*

CONCLUSION

- The State has made significant progress in promoting institutional delivery.
- Public sector share has increased over the years; Deliveries in PHCs is increasing noticeably in the recent years.
- Public hospitals play an important role in delivery services for rural poor women from socially disadvantaged caste groups.
- Wide disparities in cost of delivery care between public and private sectors.
- High probability of c-sections in the private sector calls for further probing.
- Women believe that quality of care in the private hospitals are good; and that PHCs are better than taluk or district hospitals.

ANNEXURE 3

Translating medical evidence into practice – Health and Population Innovation Fellowship project learnings on the maternal health care situation in Tamil Nadu



Survey with doctors

- 18 identified, 11 gave consent, 7 returned completed forms
- Evidence based practices not routine
  - AMTSL
  - Partogram
- Practices with no evidence base routinely practised.
  - Routine antibiotics for all deliveries
- Poor knowledge and practice – poor interest in upgrading skills

Report card monitoring quality of care

- 72 report cards filled – 70 deliveries in institutions
- Only 24 / 70 had birth companions allowed despite GO
- Only 16 / 70 received oxytocin as part of AMTSL
- Only 57 / 72initiated breastfeeding within 1 hour.

Other issues

- Abuse of women
  - Verbal, physical, emotional

When my daughter was in the labour ward, she said they hit the girl on the opposite bed, she was screaming in pain and the ayah slapped her thrice, on both cheeks and her back. When my daughter saw that, she got so scared that she bit her lips to control the pain and stop screaming. How scared she must have been to have bitten herself so much, the marks were there. The scar is still not healed. She was so scared after seeing the opposite girl being hit (Woman recounting the experience of her daughter's admission for childbirth in the medical college hospital)

Other issues - Abuse

அசிங்க அசிங்கமா திட்டறாங்க...

Using bad words…… (Woman recounting experiences of various women in the medical college hospital)

Peoples' experiences of pain vary. Some may shout amma and ayyo. They hit then. They hit even if you ask for water. (Woman recounting experiences of various women in the medical college hospital)

Other issues

- Corruption

In the medical college, they ask for 500 if it is a boy and 400 if it is a girl – if you don't pay, they refuse to show the baby. (Woman recounting her experience of going to the medical college for her daughter's delivery)

They ask you for 20 rupees to give hot water for cleaning the sutures. (Woman recounting her experience of going to the medical college for her daughter's delivery)

Every time you go in with coffee or food or anything, you have to pay 10 rupees to the watchman. (Woman recounting her experience of going to the medical college for her daughter's delivery)

Other issues

- Cleanliness

You can't enter the bathrooms. They are so dirty. They only clean it once a day. We pay 5 or 10 rupees and use the toilet outside. To wash our clothes, it is 5 rupees per piece. (Woman who delivered in the medical college hospital)

Role of TBAs

- Women and their families see TBAs as first level providers.
- Understand and accept evidence based practices.
- Facilitate better quality of care in institutions when accompanying women.

ANNEXURE 4

Quality of maternal and child health services in Tamil Nadu

Quality of Maternal and Child health services in Tamil Nadu

Indicators from the Community Monitoring and Planning Pilot Phase

Dr. Rakhal Gaitonde
Community Health Cell Extension, Tamil Nadu

Introduction

- Move towards institutionalization of much more than just deliveries.
- Institutionalization: issues

Institutionalization the larger context

- The retreat of the HI.
- Shift of the VHN to nurse.
- Shift of Immunization to the institution.
- Shift of ANC to the institution.
- Shift of delivery to the PHC.
- *"I am confident to say that every PHC will be open but I am not confident about saying that about the Sub-center"*

Institutionalization: Issues

- Capacity.
- In the context of lack of accountability.

Tale of the block with two medical colleges

- "I went to the PHC because you told me....."

(*The case of a lady who went to the PHC for delivery after insistence of our field worker and who had very bad experience including the death of the child*).

- "How will I ever go there again....."

Tale of the block with two medical colleges

"Look what they have done to me.....

(*The case of a lady who went to the PHC for delivery and had an episiotomy wound that was not properly sutured and that led to great morbidity*).

Tale of the block with two medical colleges

"The doctor is camping in the village....."

(*Case of the Maternal death that occurred due to excessive bleeding, where the mother died on the way to the higher center. The doctor was camped in the village to convince the family that it was due to "heart disease" and not negligence or lack of facilities*).

Tale of the block with two medical colleges

Thus at the end of it all the people ask our volunteers ....

"How will I ever go there again....."

Feedback from the district hospitals

- "The surprise candidate."

(*The fact that deafness related to birth asphyxia was reported in one district hospital as the emerging problem in the last few years. This increase in birth asphyxia was directly related to increasing deliveries in PHCs which were seen as ill equipped*)

- "I am really concerned....." (A pediatrician expressing concern over the increasing incidence of birth asphyxia which is attributed to increasing deliveries in PHCs that are ill equipped).

Feedback from the district hospitals

"I am really concerned....."

(*A pediatrician expressing concern over the increasing incidence of birth asphyxia which is attributed to increasing deliveries in PHCs that are ill equipped*).

ANNEXURE 5

STATEMENT OF CONCERN

We, a group of academicians, researchers and activists concerned with women's health, met on 19th September 2009 in Chennai, to discuss our concerns regarding the present situation of maternal and neonatal health care in Tamil Nadu. The meeting was jointly organized by Rural Women's Social Education Centre, Chengalpattu, CommonHealth (Coalition for Maternal-Neonatal Health and Safe Abortion) and Makkal Nalavazhvu Iyakkam.

We believe that Health is a Human Right and that one of the core components for achieving Health for All is to ensure universal access through a public health system and a well regulated private sector. We also believe that the woman should be at the centre of all planning and implementation of interventions for maternal health care and her perspectives should inform maternal health policy.

One of the major strategies of the National Rural Health Mission for the reduction of Maternal Mortality has been to encourage institutional deliveries. In Tamil Nadu, where there is already a good public health infrastructure, this has translated into a significant increase in deliveries in the public sector and a move away from the private sector. We also note with some concern that there has been a shift in deliveries from the subcentre to the primary health centre. While appreciative of the shift of births to the public sector, some new concerns have also arisen especially in the light of the near coercion to deliver in public facilities because of the link to cash incentives through maternity benefit schemes and the lack of capacity for provision of quality health care in public health facilities.

Based on the discussions in this meeting, we express the following concerns.

- ✡ It became amply clear through the various presentations from the field that "institutional delivery" did not automatically translate into "safe delivery". In other words, an institutional delivery is not necessarily a safe delivery.
- ✡ Staff in PHCs were in many instances not skilled enough to handle maternal or neonatal emergencies; there were delays in referral from PHCs to secondary or tertiary facilities; and the latter were often short of staff and facilities to handle the sudden increase in demand. The delays were attributed to non-recognition of the problem in an early stage, lack of transport in some cases, but above all due to having to go only to a government facility in order to be eligible for the cash incentive under NRHM.
- ✡ Anecdotal reports of increase in maternal and neonatal morbidity were shared – there does not seem to be any system of recording/monitoring such morbidity.
- ✡ Widespread systemic apathy, corruption and abuse of women in labour in public hospitals (secondary and tertiary level) were reported. Such practices severely compromise the quality of care and dignity of the woman and newborn.
- ✡ Special needs of marginalized groups like HIV +ve women and migrants are not being adequately met.

In summary, it was clear that while with the introduction of incentives, the proportion of deliveries in public hospitals was increasing, this was not matched by adequate systemic inputs required to enable the public health system to provide quality services from a rights based perspective, compromising the goal of making every delivery safe.

The participants felt that safe delivery including overall well being of the mother and newborn should replace mere institutional delivery as an indicator of quality Maternal and Child Health services. Every delivery, regardless of where it takes place, should be safe for both the woman and newborn, both from a technical perspective and a rights based view. Necessary systemic changes need to be made to achieve this universally.

The participants called upon the government of Tamil Nadu, well known for its leadership and achievements in improving availability of and access to maternal health services, to now turn its attention to quality and safety of deliveries and to the reduction of maternal and neonatal morbidity.

Endorsed by:

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Ganthimathi Jayaraman	International Federation of Red Cross + Red Crescent Societies, Consultant
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R Sukanya	Community Health Cell, Bangalore
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Padmini Swaminathan	Professor, MIDS, Adyar, Chennai
Bhavya	Community Health Cell, Bangalore
Rakhal Gaitonde	Community Health Cell, Chennai
B Subha Sri	Reproductive Health Clinic-RUWSEC, Karurumarapakkam Village, Thirukazhukundram via Kancheepuram. Dt, Pin 603109.

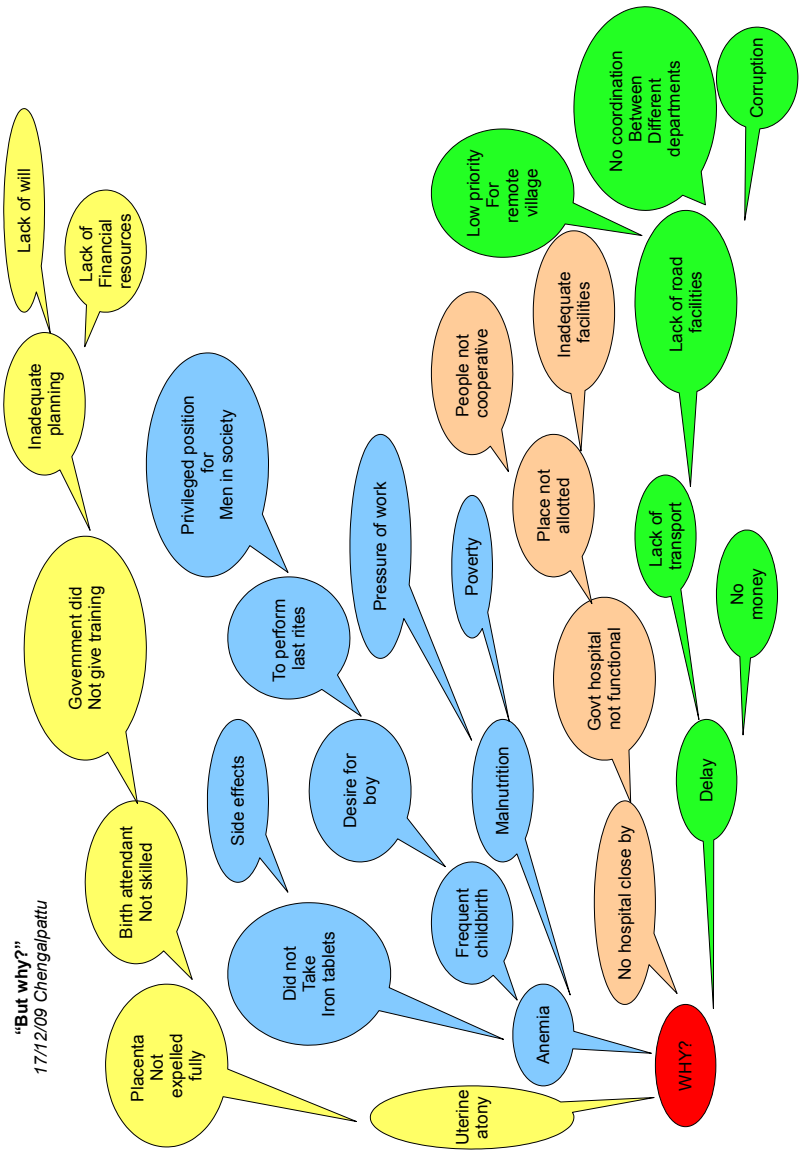
ANNEXURE 6

List of participants in grassroots consultation 17/12/09
Chengalpattu

S.No.	NAME	PLACE
1	R.MARY	AMOOR
2	G.BAMA	CHENGALPATTU
3	S.GERSI KAMALABAI	VALLAM
4	V.SHANTHI	VEERAPURAM
5	T.VIMALA	RAVATHANALLUR
6	V.DHAYALAMMAL	THAIYUR
7	P.MAGESHWARI	IRUMPULICHERRI
8	S.MALIGA	SALUR
9	YASODHA	SALUR
10	R.CHITRA	KUZHIPADANDALAM
11	T.JAYALAKSHMI	NEW KALPAKKAM
12	S.REVATHI	KATOOR
13	S.JAMUNABAI	KOTHIMANGALAM
14	M.LALITHA	NARASANGKUPPAM
15	S.GUNASEELI	MUDAIYUR
16	K.BHAVANI	CHENGALPATTU
17	G.KALAVATHY	ACHARAVAKKAM
18	Y.THERESA	KALANIPAKKAM
19	K.TAMILSELVI	POOYELUPPAI
20	P.KOMALA	KALPAKKAM
21	D.AMUDHA	EDAIYATHUR
22	AMEERKHAN	CHENNAI
23	P.R.DEEPA SAI	TAMBARAM
24	N.SRILAKSHMI	CHENNAI
25	E.CHELLAMUTHU	THIRUKAZHUKUNDRAM
26	B.SUBHASRI	RUWSEC CLINIC
27	P.BALASUBRAMANIAN	RUWSEC
28	D.SELVI	RUWSEC

ANNEXURE 7

"But Why"



RUWSEC

Rural Women's Social Education Centre (RUWSEC) is a non-governmental women's organisation started in the year 1981 by a team of 13 women of whom 12 were dalit women from the local villages of Chengalpattu taluk near Madras (Chennai) in Tamil Nadu.

Achieving women's wellbeing through women's empowerment is our organisation's vision. Our focus has been on enabling women to gain greater control over their bodies and their lives and achieving wellbeing, through promotion of gender equality and sexual and reproductive rights.

Since its inception, RUWSEC was a grassroots organisation with community-based workers drawn from the local villages. Our approach was to motivate, educate and organise women from poor and marginalised communities to stand up for their rights and become agents of change. We wanted rural poor women to be able to analyse the socio-economic and political factors underlying their lack of good health and control over their sexuality and fertility and to have the knowledge and skills to alter their own situations.

Since 2004, the organisation has transformed into a research, training, advocacy and technical support organisation providing inputs to grassroots organisations in Tamil Nadu which are working on gender, reproductive, sexual health and rights. In addition, we have helped the formation of a group of grassroots organisations under the leadership of former RUWSEC workers, working on sexual and reproductive health and rights, and have been providing them with financial support and technical guidance for effective implementation.

The Executive Director,
Rural Women's Social Education Centre –**RUWSEC**,
Tamil Nadu, India.

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